

# Rituximab Referral Form



**Patient Preferred Clinic** (select one):

## PATIENT INFORMATION

**Referral Status:**  New Referral  Updated Order  Order Renewal

DOB:	Patient Name:	Patient Phone:	
Patient Address:		Patient Email:	
NKDA Allergies:	Weight (lbs/kg):	Height:	
ICD-10 code (required):	ICD-10 description:	Last Treatment Date:	Last 4 SSN:

## PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

## NURSING

Infusion to be administered per Vivo protocols.

**RITUXIMAB THERAPY ADMINISTRATION: Many payors require patients start therapy with a rituximab biosimilar. Choose ONE of these two options:**

## LABORATORY ORDERS

CBC at each dose every \_\_\_\_\_  
 CMP at each dose every \_\_\_\_\_  
 CRP at each dose every \_\_\_\_\_  
OTHER \_\_\_\_\_

Infuse **Rituximab (Rituxan)** OR **Rituximab biosimilar/generic** as required by patient's insurance.

Do not use biosimilar/generic (subject to prior authorization).

## PREMEDICATIONS

acetaminophen (Tylenol) 500 mg 650 mg 1000 mg PO  
cetirizine (Zyrtec) 10mg PO  
loratadine (Claritin) 10mg PO  
diphenhydramine (Benadryl) 25 mg 50 mg PO IV  
methylprednisolone (Solu-Medrol) 40mg 125mg IV  
hydrocortisone (Solu-Cortef) 100mg IV  
Other: \_\_\_\_\_  
Dose: \_\_\_\_\_ Route: \_\_\_\_\_

**Dose:** 1000 mg 375 mg/m2 500 mg

Other: \_\_\_\_\_

## Frequency:

One time dose

Day 0, repeat dose in 2 weeks, then repeat course every \_\_\_\_\_

weeks OR \_\_\_\_\_ months x \_\_\_\_\_ months

Day 0, repeat dose in 2 weeks

Weekly x 4 weeks

Every 6 months x \_\_\_\_\_ months

Other \_\_\_\_\_

*\*\*Order is valid for one year unless otherwise noted\*\**

## REQUIRED DOCUMENTATION

Patient Demographics

Insurance Card /Information

Progress Notes Supporting DX

Current Medication List and H&P

Hep B Surface Antigen (within 36 months)

Hep B Core (if available)

Provider Name (Print)	Provider Signature	Date
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## Fax Numbers

Virginia: 804-500-5941	Nevada: 702-489-5744	Massachusetts: 800-540-1852
Colorado: 303-418-4679	New Jersey: 609-955-3711	Pennsylvania: 215-399-9244
Florida: 904-930-4211	Ohio: 216-400-0674	New York: 800-540-1852
Texas: 469-340-0044	Oklahoma: 918-770-4421	Connecticut: 203-724-4838

**Have a Question? (720) 902-4111**

**Email Referrals To: [referrals@vivoinfusion.com](mailto:referrals@vivoinfusion.com)**

**Email Specialty Referrals to:  
[info@specialtyinfusion.com](mailto:info@specialtyinfusion.com)**